2024 Pay for Performance (P4P) & 2025 Value Based Reimbursement (VBR) Frequently Asked Questions (FAQ)

Background

HMS offers 2 incentive programs. The first incentive program is our Performance Index or Pay for Performance (P4P). The second incentive program is an **optional** value-based reimbursement (VBR) program for specialty **physicians**. The VBR funding is separate than the P4P program and is distributed through physician billing. In October 2023, the HMS Program Manager conducted several drop-in sessions to answer questions related to the upcoming P4P and VBR incentive programs. This document is a collection of questions from those sessions and other questions received. This document will be updated on an as needed basis during the performance year. The questions have been grouped into categories below.

Pay for Performance (P4P)

Question: For optional 5 points, can you only receive these points if you are lacking in another area? Meaning, you cannot exceed 100% on the scorecard, correct?
Answer: You are correct, the optional 5 bonus points would take place of an area where your site is behind in points. Sites cannot receive above 100%.

Question: Is there official guidance about what to do when a case is complete but awaiting feedback on a ticket sent in?
Answer: When a case is completed yet you are awaiting feedback from the Coordinating Center, we ask that you leave the question blank, submit all forms and complete the case. Once you have received the response from the Coordinating Center you can then go back and answer that question.

Question: For Measure 9 (Critical Care), what if a hospital has ≤30% of PICCs placed in critical care patients are triple lumens but do not meet the participation criteria of attending the special population workgroup in that content area?
Answer: If a hospital meets the threshold but not the participation criteria, they would be eligible for partial points (i.e., 10 points).

Question: For measure 9 (Critical Care) in the Prior to 2020 Cohort, is the measure about reducing triple lumen usage in PICCs only or Midlines as well?
Answer: Below is a screenshot of the goal the hospitals that joined prior to 2020 will be working on. Although the official measure is specific to reducing triple lumen PICCs in the ICU patient, the special population workgroup meeting will likely be discussing all devices. We will be discussing specific cases and sites will be doing presentations.

Critical Care (ICU)[15]	
≤ 30% of PICCs placed in critical care cases[15] are triple lumens **AND** Participation in special population workgroup[16,17,18]	15
≤ 30% of PICCs placed in critical care cases[15] are triple lumens **OR** Participation in special population workgroup[16,17,18]	10
> 30% of PICCs placed in critical care cases[15] are triple lumens **AND** No Participation in special population workgroup[16,17,18]	0

Question: Please clarify the statement: "AND in for ≤ 5 days". Is "≤ 5 days" referring to triple lumen catheters only or ALL PICC catheters placed?

Active Malignancy[14]	
≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **AND** participation in special population workgroup[16,17,18]	15
≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **OR** participation in special population workgroup[16,17,18]	10
> 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **AND** No participation in special population workgroup[16,17,18]	0

Answer: For the Active Malignancy section in the Performance Measure, the "and in for ≤ 5 Days" it is calculated by the following:

Measure 9 (Active Malignancy) = $\frac{Triple\ lumen\ PICCs\ and\ /\ or\ PICCs\ in\ for \leq 5\ days\ \ in\ oncology\ cases}{Total\ number\ of\ PICCs\ placed\ in\ oncology\ cases}$

The definition of oncology = PICC placements where the medical record reflects a cancer diagnosis AND the PICC was placed for a cancer-related admission.

Question: Does the HMS Pay for Performance Calendar run Jan to Dec or July to June?
Question: What quarter of data are the HMS measures assessed on?
Answer: The period of assessment specifically depends on the measure. Please see below for the list of measures and their respective assessment periods by initiative.

Pay for Performance (P4P) – PICC/Midline Measures			
Measure	**Assessment Period**	**Line Insertion Dates**	**Cohort**
Reduce triple lumen PICCs and ≤ 5-day dwell times in Heme/Onc patients and participate in special population workgroup	Q1 2024 – Q4 2024	11/09/23 - 11/06/24	Prior to 2020
Reduce triple lumen PICCs placed in Critical Care patients and participate in special population workgroup	Q1 2024 – Q4 2024	11/09/23 - 11/06/24	Prior to 2020
Reduce PICCs placed in patients with eGFR < 45 without nephrology approval	Q4 2024[1]	08/01/24 – 11/06/24	Cohorts 2020 & 2021
Reduce PICCs in ≤ 5 Days	Q4 2024[1]	08/01/24 – 11/06/24	Cohorts 2020 & 2021
Increase use of single lumen PICCs in Non-ICU cases	Q4 2024[1]	08/01/24 – 11/06/24	Cohorts 2020 & 2021

1. Adjusted model uses improvement over 1 year to inform the fourth quarter score

Pay for Performance (P4P) – Antimicrobial Measures			
Measure	**Assessment Period**	**Discharge Dates**	**Cohort**
Increase use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	Q4 2024[1]	8/1/24 – 11/6/24	All Cohorts
Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB) and Questionable Pneumonia	Q4 2024[1]	8/1/24 – 11/6/24	All Cohorts
Collaborative Wide Measure: Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics for Patients with Uncomplicated CAP	Q4 2024[1]	8/1/24 – 11/6/24	All Cohorts

1. Adjusted model uses improvement over 1 year to inform the fourth quarter score

Pay for Performance (P4P) – Antimicrobial Measures			
Measure	**Assessment Period**	**Discharge Dates**	**Cohort**
Increase Antibiotics Delivered within 3 hours of Arrival for Septic Shock Patients	Q4 2024	06/02/24 – 9/07/24	All Cohorts
Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to Home-like Setting	Q4 2024	06/02/24 – 9/07/24	All Cohorts

Question: How do we find out what the monetary reimbursement amount is based on our performance?
Answer: As for the monetary reimbursement, each hospital is unique in terms of the pay for performance payment from BCBSM and it depends on numerous different factors including the size of the hospital, how many CQI's your hospital participates in, etc. The CQI Coordinating Centers don't have access to this information. I would suggest reaching out your Pay for Performance contact at your hospital. Additionally, you could also email BCBSM Value Partnerships team directly at valuepartnerships@bcbsm.com. Lastly, I've provided the link to the document that describes how the funding works from BCBSM. 2023 Hospital Pay for Performance Program (bcbsm.com)

Value Based Reimbursement (VBR)

Question: What are the eligibility requirements for the HMS VBR Measures?
Answer: To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the collaborative
- Be a member of a PGIP physician organization for at least one year
- Submit National Provider Identifier (NPI) number to the HMS Coordinating Center via the HMS 2024 Semi-Annual Fall QI Survey

Question: What is PGIP?
Answer: PGIP stands for Physician Group Incentive Program (PGIP). Launched in 2005 by Blue Cross Blue Shield of Michigan (BCBSM), the Physician Group Incentive Program includes over 20,000 primary care and specialist physicians throughout Michigan in provider-led clinical quality improvement efforts. The program connects approximately 40 physician organizations (representing these 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan.

Question: How does an individual physician know if they are part of PGIP?
Answer: To confirm if you are a member of the Physician Group Incentive Program (PGIP) through Blue Cross Blue Shield of Michigan (BCBSM), the most accurate and up to date method is to contact your physician organization. If you have any additional questions, please contact Elizabeth McLaughlin, MS, RN at emcnair@med.umich.edu.

Question: How will the physicians be identified?
Answer: HMS does not collect physician specific data in our registries, therefore, all VBR assessments will be based at the hospital. For those hospitals/physicians that are eligible for the VBR incentive, HMS will be collecting the National Provider Identifier (NPI) number for each specialty at your hospital. The NPIs will be collected in the Fall 2024 Semi-Annual QI Survey. Each hospital will be responsible for obtaining the list of NPI numbers and the Physician Champion must approve of the final list.

Question: Will physicians be enrolled automatically in the Value Based Reimbursement program through HMS?
Answer: No, physicians will not be automatically enrolled to be eligible for a given HMS VBR measure. To be considered, your hospital will need to provide the NPI numbers of the eligible physicians who represent each specialty at your hospital in the Fall 2024 QI Survey.

Question: How will the Physician NPIs for each provider specialty be obtained?
Answer: HMS collects data on a sample of patients at each hospital and therefore do not collect provider specific data. Each Fall in our HMS semi-annual quality improvement (QI) survey, we will ask for the list of NPIs for each specialty provider who

has practiced (or billed) at your hospital within the last year. Additionally, we will require that the physician champion for each hospital attest to the list of names provided in the survey. If a hospital does not provide the NPIs, even if the hospital meets the measure, they will not be eligible for the incentive.

Question: My hospital is NOT in the 2020 Cohort, are the physicians at my hospital eligible to participate in the VBR measures?
Answer: Yes, irrespective of when your hospital joined in HMS, specialty physicians at your hospital are eligible to participate in the HMS VBR measures as they long as they meet the other eligibility requirements.

Question: Do the HMS value-based reimbursement measures run January to December or July to June?
Answer: The period of assessment specifically depends on the measure. Please see below for the list of measures and their respective assessment periods by initiative.

2025 Value Based Reimbursement (VBR) Measures		
Measure	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	Reduce triple lumen PICCs placed in Critical Care patients and participate in special population workgroup
Specialist	Hospitalists and Infectious Diseases Physicians[1]	Critical Care
Assessment Period	Q3 2024	Q1 2024 - Q3 2024
Discharge Dates/ Line Insertions	5/9/2024 - 7/31/2024	11/9/2023 - 7/31/2024
Method	Adjusted – Hospital Specific	Raw – Hospital Specific
Cohort	All	All

[1] Infectious Diseases Physicians involved in antibiotic stewardship programs at local hospital

Question: Does the hospital specific structure of how physicians are funded impact the VBR incentive?
Answer: Each hospital is unique in terms of funding structure (i.e., physicians employed by the hospital vs. privately funded). The incentive will be distributed through the Physician Organization (PO). Engagement in VBR (by the participating physicians) may depend on how your hospital is structured.

Question: For the hospitalist VBR measure, does it apply to the entire hospitalist team working at one specific hospital?
Answer: Yes, the hospitalist VBR measure on increasing use of 5 days of antibiotic treatment in Uncomplicated Community-Acquired Pneumonia (CAP) applies to the entire team of hospitalists working at each hospital. Of note, the hospitalist must be a member of a PGIP physician organization for at least 1 year.

Question: Who is responsible for collecting, tracking, and submitting the information for the VBR?
Answer: The collection of data and tracking will be on the part of us here at the Coordinating Center of HMS. We will provide your hospital's data in terms of performance for each of these measures. It is your hospital's responsibility to communicate that data out to the stakeholders. For example, CAP 5 Day VBR measure, we do not have a mechanism to contact each hospital's hospitalist group to make them aware of this opportunity. This would be something your hospital would need to communicate to them in terms of the opportunity. Some hospitals may use this to increase engagement. In terms of submitting the information for VBR, in the Fall 2024 QI survey we will ask for the NPIs of the physicians that represent each specialty at your hospital which will then need to be approved by your physician champion. Then, we at the Coordinating Center will communicate who is eligible to BCBSM.

Question: At my hospital, our Hospitalists are also our Critical Care providers as they all rotate to cover the ICU. With the VBR model, will they receive incentive payments for both CAP 5 Day and Critical Care measure?
Answer: A given provider can only receive the VBR incentive for one measure, even if they count as a provider in multiple specialty measures and the targets are met. Their VBR incentive is capped at a maximum percentage. The good thing is if they fall into 2 or more measures, they have a higher chance of getting the incentive.

Question: If we don't meet the measure that a Critical Care Physician attends 3/3 special population workgroup meetings per year, are none of our physicians eligible for VBR or does this just pertain to critical care?

Answer: For VBR, each of the "Specialty" areas are independent of each other. If your Critical Care Physician doesn't attend the 3/3 special population workgroup meetings it only means the Critical Care VBR that won't be met.

Question: One of our physicians had a question regarding the special population workgroup. We've been assigned critical care, but we were wondering if this is limited to only Internal Intensivists. Or could it be from other intensivists who also manage our critical care patients? Such as pulmonary intensivist, anesthesia intensivist, surgical intensivist, etc.
Answer: Yes, any intensivists that manage critical care patients is fine although I would lean towards pulmonary/critical care. Surgical intensivists may not be as relevant, but I would leave that up to you to determine. The goal is to identify a critical care physician that cares for the medical patients at your hospital.

Question: For a physician who practices at my hospital but does not officially work at my hospital, how will they receive the funds? For example, several of our physicians technically work for Wayne State University Medical. Will the funds go to Wayne and then directly to them? Our physician champion was wondering how the money is dispersed and who it goes to.
Answer: The VBR is a fee schedule increase that is applied to the physicians billing for BCBSM commercial PPO claims. The VBR you earned will show up on each claim billed and will look like an increase in reimbursement. For instance, if the doctor (or the doctor's agency that handles billing), bills for a consult code that would pay out at $100. If that physician earns a 3% VBR, then the reimbursement would show up at $103. The VBR is tied to the physician billing and nothing else. It's not tied to facility billing. But, if the physician is employed by a hospital or large group, the physician will not necessarily see the increase. If the physician in this case is employed by a hospitalist group but not your hospital, whoever manages and administers the PHYSICIAN billing will see this increase in reimbursement on each claim (with the exception on certain claims related lab, rad, diagnostics, DME, ambulance/air transport). The VBR is primarily applied to Relative Value Unit based codes (which include your E&M, consult, and procedure codes). If the doctor wants to know who's aware of their VBR, it would be the PO, but the PO doesn't get the VBR and they don't disburse the VBR. The only thing the PO does with VBR is they know who received it and they get reports from BCBSM on how much the total VBR earned was for the period. One important question to determine is whether the interested physicians are part of the Physician Group Incentive Program (PGIP) program which is typically asked through the physician organization.

Question: I would like to get an estimate on the dollars potentially involved, could you help with fine details on the calculations?
Answer: HMS is not able to provide this information as it depends on several factors that HMS does not have access to. For example, the providers that would be eligible must be part of the Physician Group Incentive Program (PGIP) program through BCBSM. The other factor is the uplift is distributed through BCBSM claims and HMS is not aware of the % of BCBSM claims that are submitted by specialty physicians at your hospital.

Question: Is it a system wide reimbursement? Are all providers eligible for reimbursement or just those involved with HMS work?
Answer: All hospitalists, and separately Infectious Diseases Physicians who are part of the antimicrobial stewardship teams at the individual hospital, who have practiced over the last 1 year at the individual hospital being assessed. I want to clarify that we assess the data at a local hospital level (not at the system level) who meet the eligibility requirements below.
To be eligible for 2024 CQI VBR, the practitioner must:

- Meet the performance targets set by the collaborative
- Be a member of a PGIP physician organization for at least one year
- Submit NPI number to the HMS Coordinating Center via the HMS Semi-Annual Fall QI Survey

Question: Is the reimbursement received over a period of time?
Answer: The payout/reimbursement period is from 3/1/25 – 2/28/26.

Question: I would like to know, if I as the abstractor have any role to play in the VBR measures.
Answer: Your role is to help share the opportunity that is available. VBR is optional and not required. If your hospital is looking to obtain the incentive, your role (and your physician champion) will need to help obtain the NPI's and attest that those individuals have practiced at your hospital within the last year.

Question: Is the target performance required to be met by each provider individually, or just by our group? I assume the target performance is measured based on whole GROUP, but VBR payment applies only to individually eligible providers' billings.
Answer: Yes, the performance is assessed at the hospital level, not individually. This is the reason we have to collect the NPI's at every hospital because HMS doesn't have their Names/NPI's in our registry. Basically, if your hospital meets the target – all providers will get the incentive and it will go through their individual billings.

Question: For the infectious disease physicians, are they eligible even if they practice outpatient too? I think most of them see patients in a clinic setting for follow-up, as well as in the hospital.
Answer: Yes, they are eligible if they see patient's outpatient as well – as long as the other eligibility criteria are met.

Question: Our physicians see patients at 2 hospitals. Can they receive HMS VBR from both, or just one?
Answer: BCBSM has confirmed that a physician can only receive one VBR even if they practice at 2 hospitals.

Question: What is involved for providers to participate?
Answer: Please see the fact sheet for details. In order to be eligible they must be enrolled in the BCBSM PGIP Program and meet the target performance that we set for the specific measure. To find out if they are enrolled in PGIP they would need to work with their physician organization (PO) to determine this. The measure is assessed using our HMS measures so there is no additional data collection. If your hospital meets the target performance then the physicians will receive the incentive. The most important thing is if your hospital is not meeting the target performance below, then the biggest task is to help improve the scores in these areas for your hospital. For example, if your hospital is not meeting the CAP 5 Day target performance of $\geq$70% of uncomplicated CAP patients receiving 5 days of antibiotic treatment (i.e. reduce antibiotic duration), then it would be important to bring them into the discussion on how to improve. I would recommend involving them in reviewing cases where patients received more than 5 days of therapy to help identify opportunities for improvement. To be honest, if your hospital is meeting the thresholds already, there is no downside to submitting the NPI's as they will get the incentive since they are already doing well.

Question: Do we need their permission or can we enter them all?
Answer: No, you don't specifically need their permission. I would let them know that this opportunity is available for them to receive additional incentives from BCBSM claims.

Question: We were wondering who exactly qualifies as a hospitalist for this program? Are internal medicine and family medicine physicians included? We have many physicians that round on patients in the hospital for their own and other physician's patients, but aren't categorized as the "typical hospitalist" that we feel should be included, but wanted to clarify before proceeding.
Answer: At this time, the VBR program is only eligible for physicians classified as hospitalists at your institution. If there are general internists who only practice in the hospital, they can be "categorized" as a hospitalist when you provide the list of physicians in the Fall. In the situation where internal medicine physicians/family medicine physicians practice in outpatient/ambulatory care determining the VBR incentive/eligibility creates significant challenges as there are also VBR measures separate from HMS for these providers. We decided with BCBSM that at this time we will only provide the incentive for hospitalists.

Question: Speaking for my site, the administrator does not understand any of the VBR information.
Answer: If you have reviewed the FAQ Document and all of the resources posted relating to the VBR information and still have additional questions, please reach out to Elizabeth McLaughlin at emcnair@med.umich.edu

Question: I would ask that abstractors be removed from this process, can we just provide the information and direct the physicians to HMS for questions?
Answer: We can't eliminate abstractors from the VBR communications and process, as you are our connection to each hospital. It is also important to be aware. Administrators can contact Elizabeth McLaughlin at emcnair@med.umich.edu

Question: We will need to know the dates that you require those specialists work. For example, do they have to had worked on October 1, 2023? Or, did they have to have worked 6 of the last 12 months, etc.

Answer: We are not making the determination on whether those physicians specifically worked, we are just asking you to identify those who worked in your hospital over the last year. We are relying on you to give us the information of those physicians.

Question: For VBR, would it be possible that physician groups signed up for this without the hospital knowing? We decided not to really publicize it.
Answer: No. The only way that they could get the incentive is if you provide these NPI's in the survey, so there's no other mechanism for how they would get these VBR incentives except through this survey.

Question: Who is asking the providers whether they plan to participate- us or HMS?
Answer: We announced the opportunity for VBR at our November Collaborative Wide meeting. We also held 3 drop in sessions in October 2023. If your hospital announced it separately, that's how it would have been shared. The other possible way that it could have been shared is at the BCBSM level. BCBSM shares VBR opportunities across their provider network and they may have heard about it through that. Typically, it would have been through you, the abstractor or us at HMS if they came to our Collaborative Wide meeting and reached out.

Question: I had also asked about the Infection control docs. It states that they need to be active on the infection control team. What does that mean? Do they have to attend 50% of the meetings? Can they just read the minutes after the meetings? So a provider that worked one month of the past year could be included?
Answer: The infectious diseases physicians must be participating in your antimicrobial stewardship work at your hospital. It's not specifically the infection control team. It's if they're involved with stewardship at your hospital. So, let's say your hospital meets quarterly to review your antimicrobial data from HMS and you have an infectious disease physician at that meeting, that would be a perfect person that would be eligible for it.

Question: Asked physician leaders if participating--should we be opening this up to ALL hospitalists?
Answer: Yes, as long as they are participating at your hospital.

Question: For more information about HMS VBR, who should I direct the physicians at my hospital to for questions/concerns?
Answer: For detailed information regarding the HMS CQI and specific details to the measures and methodology of HMS VBR, please contact Elizabeth McLaughlin, MS, RN at emcnair@med.umich.edu. If you would like to know more information about the program in general through Blue Cross Blue Shield of Michigan, please contact Marc Cohen at mcohen@bcbsm.com.

PICC Special Population Workgroup

Question: After reviewing the slides from the collaborative wide meeting, can you please elaborate on the rationale for the format of the workgroup to meet the PICC metric?
Answer: The new PICC strategy related to PICC use in hematology/oncology patients and critical care patients was developed over the last year based on feedback from our participating hospitals on further areas for improvement. These patient populations have been identified by HMS hospitals as challenging to determine the best approach. The focus of this new strategy is to identify, as a Collaborative, the best approach to device use in these specific patient populations. This is why the workgroups are so important and include the multidisciplinary providers that are key thought leaders in this area (i.e., quality staff and the specialist physician [i.e., hematologist/oncologist or Critical Care Physician, Vascular Access, or Interventional Radiology]). The goal is to (try!) to come to a consensus that our Collaborative can use for decision making – similar to how we developed the MAGIC guidelines.

Question: I would like to reach out to one of our critical care physicians to inquire about attending one of the special population workgroup meetings next year. What is the best way to communicate the goal/purpose?
Answer: Please see some sample wording below to use in your communication:
"[Hospital Name] participates in the Michigan Hospital Medicine Safety (HMS) Consortium, a Quality Collaborative funded by Blue Cross Blue Shield of Michigan (BCBSM). Each year, [Hospital Name] is assessed on our performance related to appropriate antimicrobial use, care of patients with Sepsis, and appropriate use of PICC and Midline devices. For the PICC work specifically, the Collaborative has largely focused on improving vascular device use in the general medical patient. Over the last several years, the collaborative has begun to assess device use in the critically ill patient and separately oncology patients. Starting in 2023, the collaborative will be convening 2 special population workgroup meetings to discuss appropriate device decision

making in these groups with the goal of identifying a list of standards/principles for device decision making (i.e., clinical scenarios warranting triple lumens, etc.). Although the Collaborative's focus to date has largely been on PICC/Midline use, we anticipate the focus of the workgroups will be more all-encompassing. Given when [Hospital Name] started with HMS, we are not officially assessed on our use of triple lumen PICCs in the ICU for reimbursement purposes, we have the opportunity to achieve bonus points to help offset some of our other measures we are assessed on. To receive bonus points, a specialist in critical care, must attend 1 workgroup meeting throughout the year. "

Question: Can you also clarify how many times the workgroup will be meeting and detail how meeting the metric will be assessed?
Answer: The workgroup will be meeting 3 times during the calendar year virtually for 1 hour each. We will be tracking participation via Zoom registration/attendance tracking. Zoom will report who attended and the time frame they attended. During the registration process, we will ask the for the specific specialty to be able to track this.

Question: For specialist attendance at the special population workgroup meetings, does it need to be the same specialist at every workgroup? Like if 2 different oncologists attend?
Answer: For specialist attendance at the special population workgroup, it **does not** have to be the same specialist that attends each meeting. For example, if critical care physician #1 attends the March meeting, critical care physician #2 can attend the July meeting, etc.

Question: Two hospitals within my system of hospitals are paired together. Can you tell me if this means that the attendance requirements for this workgroup can be met between the two hospitals or does each hospital have to have all required attendees?
Answer: The attendance requirements are specific to each hospital (i.e. each hospital is required to have all attendees). For pairings, only data portion of the assessment will be paired.

Question: Does Vascular Access attendance count at all? I thought if we had a member from the Vascular Access team that would meet the requirement for the extra points.
Answer: No, vascular access team members do not count as the 'specialist' for bonus points. Attached is the performance index for reference. Footnote 18 defines the specialist.

> [18] Specialist is considered Critical Care, Oncology or Hematology Physician
>
> - Oncology workgroup area = Oncology or Hematology Physician
> - Critical Care (ICU) workgroup area = Critical Care Physician
>
> If hospital does not have a specialist either employed at the hospital or contracted by the hospital, the HMS Physician Champion is acceptable, however, must be approved by the Coordinating Center.

Question: For the workgroup, can we utilize more than one person?
Answer: For participation in the workgroups, we do not require that the same person be present for each meeting. It is more about the role itself. For example, if this is a vascular access professional, any of the other vascular access professionals on the team could attend as well.

Question: Can an infectious diseases physician attend one of the special population workgroups for bonus points?
Answer: No, for bonus points related to the specialist attending at the special population workgroup meetings, an infectious diseases (ID) physician does not count. For the critical care workgroup, the specialist must be a critical care physician. For the active malignancy workgroup, the specialist must be an oncologist or hematologist.

Question: We are in the 2021 cohort. Are the Pay for Performance (P4P) bonus points tied to attendance at the special population workgroup by critical care and oncology/heme? Would it count if just an Interventional Radiologist from my site attended?
Answer: For hospitals that joined HMS in 2020, 2021 or 2022, you are eligible for bonus points. To receive bonus points, a critical care physician could attend 1 critical care special population workgroup meeting, or a hematologist/oncologist could

attend 1 oncology special population workgroup meeting during the performance year to meet the requirement. No, an Interventional Radiologist (IR) would not count towards the specialist participation in either of the workgroups.

Question: Please confirm the guidelines for the oncology PICC initiative for the Prior to 2020 Cohort. I thought I understood that the specialist would need to attend 1 of the 3 meetings to receive points. If they attended all 3 then there would be bonus points?

Answer: Yes, if you are specifically speaking of the Performance Index for HMS (or P4P), then the specialist only needs to attend 1 of 3 meetings to receive the main points (non-bonus). Please note that for the oncology piece, there is also a second component which is meeting the threshold below for triple lumens and those in for ≤ 5 Days. If they attend all 3 of the workgroup meetings, they will receive the bonus points (total of 5 points). See screenshots below.

Active Malignancy[14]	
≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **AND** participation in special population workgroup[16,17,18]	15
≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **OR** participation in special population workgroup[16,17,18]	10
> 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for ≤5 Days **AND** No participation in special population workgroup[16,17,18]	0

Optional Bonus			
Optional	5	Specialist[18] attendance at 3 of the virtual special population workgroup meetings[17] during the calendar year in the hospital's pre-determined workgroup area **OR** Specialist[18] attendance at 1 or more of the special population workgroup meetings[17] that is not the hospital's pre-determined workgroup area during the calendar year	5
Optional	5	Emergency Medicine Physician attendance at the 2 in-person collaborative wide meetings convened during the calendar year (July & November)	5

Question: For critical care specialists and hematologist/oncologist specialties, would a Nurse Practitioner or Advanced Practice Provider (APP) count?

Answer: No, for the specialist component for the workgroups (critical care and hematology/oncology), an advanced practice provider (APP) will not be accepted. It must be a physician.

Question: For VAST and IR attendance, does an Advanced Practice Provider on either the Vascular Access team or an IR Advanced Practice Provider count?

Answer: Yes, for the Vascular Access Team Member or Interventional Radiologist component of the P4P workgroup participation requirements, an advanced practice provider (APP) will be accepted. Note: screenshot below from the supporting documentation of the 2024 HMS Performance Index – Prior to 2020.

[16] Participation in Special Population Workgroup

- At least 3 individuals representing the following roles must attend 3 of the 3 tri-annual initiative specific work group meetings:
  - 1 Quality Professional
  - 1 Physician (the physician in attendance for at least 1 of the 3 meetings per year must be a specialist in the special population area)
  - 1 Vascular Access Team Member or Interventional Radiologist Representative

Question: In the Performance Index (P4P), the directions for the workgroup states that a Quality Professional must attend. Do abstractors count as Quality Professionals, or does this need to be more of a Quality Improvement Specialist?

Answer: Yes, an abstractor counts toward the "Quality Professional".

Question: My hospital doesn't insert any triple lumen PICCs. Should we participate in the special population workgroup?
Answer: Yes, every hospital that joined HMS prior to 2020 will be in one of the PICC workgroups, critical care, or active malignancy, irrespective of performance. If your hospital does not insert any triple lumen PICCs in these populations, your guidance/expertise will be valued during the discussions.

Question: My hospital is assigned to *Active Malignancy.*
If our Critical Care physicians participate in the **VBR** and participated in ALL three workgroups:

1. Would they be assigned to the *Oncology* specialty workgroups or *Critical Care* specialty workgroups?
   Answer: All Critical Care physicians will be assigned to the Critical Care specialty workgroup, irrespective of which group the hospital has been assigned to.

2. If Critical Care were to attend all three Workgroups in either *Critical Care OR Active Malignancy,* would that make us eligible for the P4P bonus points or would they need to participate in at least one meeting of the other specialty workgroup?
   Answer: Good question, for **P4P**, since your hospital is assigned to the active malignancy cohort, you could receive bonus points 1 of 2 ways:
   1. Your Critical Care physician attends 1 or more Critical Care special population workgroup meeting
   2. Your Oncologist/hematologist attends 3 of the active malignancy special population workgroup meetings

   If your hospital is also going for the **Critical Care VBR incentive**, a Critical Care physician would need to attend all 3 special population workgroup meetings.

Question: Can you tell me what the data for the Special Population Workgroups will look like. For example, will the elements of the active malignancy workgroup be reported separately: ≤25% of PICCs placed in oncology patients are triple lumen, then a report for triple lumens in for ≤5 days, and another report for participation.
Answer: Yes, the reports in the HMS PICC/Midline registry are updated to reflect the combined score and the individual scores for triple lumen use and dwell times in patients with active malignancy.

Question: I am preparing our list of hospitalists for our survey. My physician included APPs in our list. VBR is only open to physicians (MD/DO), correct?
Answer: Yes, that is correct. It is only available to physicians.

Question: The physician organization sent me a list that includes all their providers by specialty but doesn't include the specific hospital they work at. Do I need to break the list down by hospital?
Answer: Yes, the list of providers needs to be differentiated by hospital even if providers work at multiple locations.

Question: We have an open ICU and I practice regularly in the ICU – I believe I had asked and I can satisfy the ICU specialist?
Answer: Yes, you qualify as an ICU specialist for HMS VBR purposes.

Question: My hospital is in Cohort 2020. We do not have an active inpatient Oncology service and acute Malignancies requiring inpatient treatment are transferred. Would we be exempted from the oncology measure when it does apply to our cohort?
Answer: All medical patients are included in the PICC/Midline measure, irrespective of their diagnosis. For this reason, we do not make exemptions for unique hospital situations with specific patient populations. At this point in time, we do not anticipate rolling out our Oncology specific measures to the newer cohorts.

Question: We have an Infectious Disease physician involved in our Antimicrobial Stewardship, but he does not provide direct patient care, rather it is more of a consultant-based role. Would his info and NPI number be needed for this question?

Answer: Yes, even if they are in a consult-based role, they would be eligible for the VBR and therefore we would need their Name and NPI.

Question: With participation in the collaborative, when successful will the 3% be an uplift on hospitalist claims or a lump sum paid?
Answer: Hospitalist BCBSM claims.

Question: Will the uplift affect primary care and specialty providers or just the hospitalists?
Answer: Hospitalists and infectious disease physicians who are part of your stewardship programs.

Question: Can you please provide the codes that will have an uplift if applicable?
Answer: We don't have a list of codes specifically from BCBSM. When asked this question of them before, this is their response. The VBR is primarily applied to Relative Value Unit based codes (which include your E&M, consult, and procedure codes).

PICC Measures – Active Malignancy and Critical Care patients – Hospital Pairings

Question: For hospitals paired together, will our score be combined with the paired hospital?
Answer: The hospital pairing is for data aggregation purposes. For hospitals that have small numbers of patients, we combined hospitals who have larger volumes within their system or with other small hospitals. Yes, the scores are combined for P4P assessment purposes.

Question: Since the P4P score is combined, will we need participation from only 1 critical specialist for both hospitals to meet the measure?
Answer: The scores are combined only for data purposes for the dwell time and/or lumens portion of the measure (i.e., determining the threshold for the <30%). This does not include the participation component in the population workgroup. So even though the hospitals are paired together, 2 critical care specialists would need to attend – 1 from each hospital.

Question: When you say the scores are combined for data purposes, will the P4P scorecard reflect the combined scores, or will each site be scored individually for P4P purposes?
Answer: Yes, the P4P scorecard (and data reports) distributed in 2024 will reflect the combined score (as well as the site-specific score). Please note, this is just for this measure and not the other measures.

Question: For the Critical Care cohort, there is a VBR measure related to reducing triple lumen in PICCs in Critical Care patients with a goal score of ≤ 30%. For sites that are in a hospital pairing, will that score be solely based on the performance of our site, or will it be combined with the other hospitals in our pairing?
Answer: The VBR measure is **hospital-specific**, and the data utilized to determine performance in this particular measure will be based on your site's performance and NOT collated by hospital pairings.

Sepsis

Question: For the septic shock measure, when does the 3-hour clock start?
Answer: The 3-hour clock starts at the time of arrival.

Question: What is the definition of septic shock?
Answer: This is noted in the performance index scorecard in the footnotes. I've pasted this here:

> [11] Cases with septic shock are defined as those with hypotension (vasopressors initiated within two hours of arrival OR systolic blood pressure < 90 mmHg within two hours of arrival OR calculated MAP < 65 within two hours of arrival). Patients excluded from review in this measure include those with < 2 SIRS, normal WBC, no elevated lactate, and no symptoms of infection.

Question: Will a combined measure be added to the live report so we can know what our overall performance is with the 3 separate discharge measures?
Answer: Yes, a combined score will be added to the HMS live and printed reports for the sepsis discharged measure.

Question: Will there be a scorecard dedicated to the Sepsis initiative?
Answer: HMS only has one Performance Index which includes all of our initiatives (Antimicrobial, PICC/Midline and Sepsis).

ANTIMICROBIAL

Question: How do you determine appropriateness of empiric broad spectrum therapy?
Answer: To determine appropriateness of empiric broad spectrum therapy, we are looking at the following:

- Respiratory/blood cultures from the prior year, including MRSA in culture or swab or Pseudomonas (or other gram negative) in culture
    - If MRSA is found – anti-MRSA coverage is appropriate
    - If PSA or other gram negative is found – anti-PSA coverage is appropriate
- If cultures do not provide information as noted above, we are looking to see if the patient had an inpatient hospitalization in the prior 90 days + IV antibiotics in the prior 90 days + severe CAP on days 1/2 of the hospital encounter
    - If they have all of these items, we will not consider the empiric start of broad spectrum coverage to be inappropriate on day 2

Question: Which antibiotics are considered broad spectrum? Vancomycin +/- cefepime?
Answer: For broad-spectrum antibiotics, we are looking at any antibiotics that are either considered to be anti-MRSA or anti-Pseudomonal/Gram Negative Coverage.
Anti-MRSA:

- Vancomycin
- Linezolid
- Ceftaroline

Anti-PSA or Gram Negative:

- Ceftazidime or Ceftazidime-avibactam
- Piperacillin-tazobacatam
- Cefepime
- Meropenem, meropenem vaborbactam, imipenem, or doripenem
- Aztreonam
- Ceftolozane-tazobactam
- Cefiderocol
- Ciprofloxacin